

BY WHOSE AUTHORITY? EMERGING ISSUES IN MEDICAL ETHICS

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DISEASE IS an awkward, deeply disturbing mystery of the human condition. Since the day *Homo erectus* first acquired a limp, we have struggled to understand why. Disease, like death, is inescapable. But from prehistoric times to the present, there have always been healers who have responded to the profound needs of the sick. Questions have sometimes arisen about the propriety of the solutions healers have offered patients for the burdens imposed by disease. Such questions constitute the bulk of the subject matter of medical morality. While it may seem to some that serious investigation of this subject began in the 1950s, medico-moral questions have been asked for many centuries. Jesus, the pre-eminent healer, was asked by the Pharisees to defend his work of healing on the Sabbath (Mk 3:1-6, Lk 6:7, Jn 5:1-18, Jn 7:14-24). He was also challenged to declare by whose authority he had cast out demons (Mt 9:32-34, Mt 12:22-32, Mk 3:20-30, Lk 11:11-23). Simon Peter, who healed in Jesus' name, was questioned by the Sanhedrin about his "act of kindness towards a cripple" (Acts 4:5-22). The questions put to these men were the medico-moral questions of their day. Jesus and Peter were asked the perennial questions which religious and moral leaders always ask healers. By whose authority do you heal? Does your healing come from God and serve God's people, or does it come from the enemies of God and constitute a disservice to God's people? Are the conditions under which you are healing right and just? Even today, when explosive developments in medical technology have created a vast array of unprecedented new problems, the most basic questions are similar to the questions which the Pharisees and the Sanhedrin asked Jesus and Peter. The circumstances in which we ask these questions have changed and they will doubtless keep changing. But if we take our cues from the present age of medicine, with its extraordinary technological capability and its deeper and deeper sense of professional agony and self-doubt, we may begin to look beyond the immediate questions of our day and explore directly the most basic questions. What is medicine? What are its goals? What is the proper social context in which to carry out justly the work of healing? What is suffering? What is disease? What is the nature of the doctor-patient relationship? And by whose authority do we heal

today? As we begin to struggle with these questions, we may discover that rather than simply preparing another treatise on the subject of contemporary medico-moral problems, we will have begun to develop a genuine moral theology of medicine.

What are some of the ways in which these questions are being asked today? This paper will address three very new questions, each an example of one of three ways in which new medico-moral issues emerge, each pointing simultaneously to more basic questions which are far from new. New issues can arise whenever (1) new therapies are discovered for old diseases, or when (2) serious, new diseases appear, or when (3) the social context in which medicine is practiced undergoes change. The transplantation of fetal nerve cells into the brains of persons suffering from Parkinson's Disease is a contemporary example of a new, morally problematic treatment for an old disease. AIDS is a contemporary example of a new disease which has raised a great many moral questions. Finally, health-maintenance organizations, which now dot the American landscape, are changing the social context in which doctors and patients relate to one another, and this development has brought to the foreground of medico-moral discussion a host of difficult questions. Space considerations will not allow exhaustive discussion. Rather, some of the possible answers to these questions will be sketched in very broad outlines. In this way some of the older, deeper moral questions raised by these three issues will emerge.

TRANSPLANTING FETAL TISSUE INTO THE BRAINS OF ADULT PATIENTS

Parkinson's Disease is a degenerative disorder of the central nervous system characterized clinically by tremors, muscle rigidity, and very slow movement. Patients often develop a "mask-like" appearance to the face, drooling, a shuffling gait, difficulty initiating any sort of movement, and dementia. Parkinson's Disease is caused by the loss of nerve cells in a deep area of the brain known as the basal ganglia. While medical therapy for this disease has been enormously helpful, it is not curative.¹ Parkinson's Disease continues to progress during treatment. In addition, medical treatment is fraught with numerous unpleasant side effects even while it is working.²

It is exciting to think that nerve cells lost from the brains of patients with Parkinson's Disease might be replaced by transplantation of fetal

¹ Eldad Melamed, "Brain Grafting May Reverse Loss of Responsiveness to Levodopa Therapy in Parkinson's Disease," *Clinical Neuropharmacology* 11 (1988) 77-82.

² Robert Y. Moore, "Parkinson's Disease—A New Therapy?" *New England Journal of Medicine* 316 (1987) 872-73 (hereafter *NEJM*).

nerve cells in order to relieve the enormous suffering and to restore the muscle function of these patients. For a variety of technical reasons, fetal nerve cells are ideal for transplantation.³ Animal experiments have been conducted for many years.⁴ Human experiments have been conducted in Sweden⁵ and in Mexico⁶ using tissue from the patients' own adrenal glands. Human fetal tissue transplants have recently been reported from Mexico⁷ and the procedure has apparently also been performed elsewhere.⁸

A great debate over the morality of this procedure has developed in the U.S. The source of fetal tissue which some medical scientists propose to use for transplantation is the preivable but living fetus expelled from the womb by induced abortion. Under National Institutes of Health guidelines, which were established in 1975, live, spontaneously aborted fetuses (i.e., miscarriages) and stillborns could be legally used for experiments if the approval of parents or guardians was obtained.⁹ Currently there is a moratorium (which has been in effect since 1985) on approval of any research proposals received by the National Institutes of Health which put the living human fetus (whether still in the womb or not) at more than a "minimal risk." Scientists are concerned that dead spontaneous abortuses and stillborns may not be as ample a source of viable tissue for transplant as are living fetuses. The U.S. Congress must now decide whether or not to extend the moratorium.¹⁰ Hearings are in

³ John R. Sladek and Don Marshall Gash, "Nerve-Cell Grafting in Parkinson's Disease," *Journal of Neurosurgery* 68 (1988) 337-51.

⁴ Barry J. Hoffer et al., "Catecholamine-containing Grafts in Parkinsonism: Past and Present," *Clinical Research* 36, no. 3 (1988) 189-95; Edwin Keister, "Spare Parts for Damaged Brains," *Science* 86 7, no. 2 (1986) 32-38; John R. Sladek, D. Eugene Redmond, and Robert A. Roth, "Transplantation of Fetal Neurons in Primates," *Clinical Research* 36, no. 3 (1988) 200-204; Roy A. Bakay et al., "Biochemical and Behavioral Correction of MPTP Parkinson-like Syndrome by Fetal Cell Transplantation," *Annals of the New York Academy of Science* 495 (1987) 623-40.

⁵ Erik-Olaf Backlund et al., "Towards a Transplantation Therapy in Parkinson's Disease: A Progress Report for Continuing Clinical Trials," *Annals of the New York Academy of Science* 495 (1987) 658-73.

⁶ I. Madrazo et al., "Open Microsurgical Autograft of Adrenal Medulla to the Right Caudate Nucleus in Two Patients with Intractable Parkinson's Disease," *NEJM* 316 (1987) 831-34.

⁷ I. Madrazo et al., "Transplantation of Fetal Substantia Nigra and Adrenal Medulla to the Caudate Nucleus in Two Patients with Parkinson's Disease," *ibid.* 318 (1988) 51.

⁸ Alan Fine, "The Ethics of Fetal Tissue Transplants," *Hastings Center Report* 18, no. 3 (June/July 1988) 5-8.

⁹ Patricia King and Judith Areen, "Legal Regulation of Fetal Tissue Transplantation," *Clinical Research* 36, no. 3 (1988) 205-8.

¹⁰ "Ban on Fetal Tissue Use Raises Concerns for Research," *Internal Medicine News* 21, no. 13 (July 1, 1988) 11.

progress.¹¹

How does one begin to understand this issue from a moral perspective? What previously encountered paradigms apply here?¹² What questions need be asked and answered before we decide whether or not to proceed with fetal transplantation? Let us examine some of the paradigms by which various authors have proposed that we may best understand this issue.

1) The situation is most like organ donation by any living donor. The mother is the subject and the fetus is disposable tissue which belongs to her, like a lymph node or a kidney. She is free to donate this tissue if she is inspired to do so.

This position has been articulated by a lawyer on the staff of a bioethics research institute as follows: "Just because a woman decides to have an abortion does not take away her property rights."¹³ The Vatican position obviously opposes this conception of the fetus.¹⁴ Mahowald, Silver, and Ratcheson afford the living, nonviable fetus a status somewhat higher than "tissue." Nonetheless, they invoke the Uniform Anatomical Gift Act in discussing the case of the living, ex-utero, but preivable fetus. The Act allows parents to give "all or part of the body of a dead fetus" for research or therapeutic purposes. These authors do not appear to recognize a moral distinction between a living, preivable fetus and a dead fetus. They conclude that it is moral to donate tissue from a living, preivable fetus if the consent of the mother is given, the research goal is "significant," and there is no other way to conduct the research.¹⁵ This is essentially a utilitarian argument to allow the use of this tissue because of social benefit. The problems with a utilitarian approach to this type of question have been clearly pointed out by McCormick in the context of his arguments urging caution in the use of fetuses for nontherapeutic research.¹⁶

2) The fetus about to be electively aborted is a condemned but innocent and exceptionally vulnerable human being. No one can claim to give consent for nontherapeutic experiments on children who are in jail or

¹¹ Joseph Palca, "Fetal Tissue Panel Labours to Beat a Presidential Ban," *Nature* 335 (Sept. 22, 1988) 291.

¹² Albert R. Jonsen, "Transplantation of Fetal Tissue: An Ethicist's Viewpoint," *Clinical Research* 36, no. 3 (1988) 215-19.

¹³ Vivian Dempsey, "Clash of Ethics," *San Francisco Recorder*, Sept. 9, 1987, 1, 18-19.

¹⁴ "Instruction on Respect for Human Life in Its Origins and on the Dignity of Procreation," *Origins* 16, no. 40 (1987) 697-711.

¹⁵ Mary Mahowald, Jerry Silver, and Robert Ratcheson, "The Ethical Options in Transplanting Fetal Tissue," *Hastings Center Report* 17, no. 1 (1987) 9-15.

¹⁶ Richard A. McCormick, *How Brave a New World?* (Garden City, N.Y.: Doubleday, 1981) 81.

institutionalized without serious risk of abusing the innocent. The living, nonviable fetus is even more vulnerable than a child and should not be experimented upon.

This is essentially the position of Paul Ramsey.¹⁷ It would also seem closest to the position of the Vatican document which prohibits nontherapeutic operations or experiments involving live embryos.¹⁸ The greatest barrier to research, which Ramsey sees as insurmountable, is the inability to obtain a valid consent. This will be discussed in more detail below.

3) The living but nonviable aborted fetus is most like a victim of a motorcycle accident who has been unfortunately killed, or even a person who has been unjustly murdered. Why not make the best of a bad situation? At least some good may come of the tragedy if tissue from the victim can be used to sustain or improve another person's life.

One medical scientist has stated the position this way: "If someone has decided to have an abortion and gives permission, it is all right to use that tissue to help someone else."¹⁹ Arthur Caplan agrees, stating that the tissue gift can be a source of solace to the parents of the fetus.²⁰ Other authors argue that this merely helps to redeem abortion, which they consider an intrinsic evil.²¹ One obvious problem with this analogy to the case of cadaveric transplantation is that the living, nonviable fetus is not, by virtue of the fact that it is still living, a cadaver. The analogy only holds when the fetus is dead. Another problem, recognized by Caplan himself, is that of consent for donation of the fetal tissue. We will address this issue in more detail below.

4) The situation is analogous to surrogate parenting. It is morally permissible for the fetus to be nurtured in the womb of a woman who does not intend to rear the child, but who becomes pregnant expressly for the purpose of donating the fetal tissue to someone else.

Mary Ann Warren has taken this stand. "A surgeon ought to agree to a woman's plan to provide her husband with the kidneys of a fetus conceived for that purpose [i.e., transplantation] and aborted at 5 to 6 months." This has been criticized as using the fetus as an "organ farm."²² It would appear, however, that Warren's conclusion is the logical extension of the position held by many that the fetus has no characteristics in

¹⁷ Paul Ramsey, *The Ethics of Fetal Research* (New Haven: Yale Univ., 1975).

¹⁸ Cf. n. 14 above.

¹⁹ Tamar Lewin, "Use of Fetal Tissue Spurs New Abortion Debate," *New York Times*, Aug. 16, 1987, 1, 30.

²⁰ Arthur L. Caplan, "Should Foetuses or Infants Be Used as Organ Donors?" *Bioethics* 1, no. 2 (1987) 119-40.

²¹ Dempsey, "Clash of Ethics."

²² Mary Ann Warren, "Can the Fetus Be an Organ Farm?" *Hastings Center Report* 8, no. 5 (1978) 23-25.

common with the community of "persons" to whom one may assign rights, and that it is the right of the woman to dispose of the fetus as she wishes. A California woman has reportedly inquired about the possibility that she might be artificially inseminated with her father's sperm so as to use the tissue from the resultant fetus for transplantation into the brain of her ailing father.²³ In response to such possibilities, Mahowald et al.²⁴ and Fine²⁵ have proposed that donors and recipients remain anonymous. They also propose that the sale of fetal tissue be prohibited. Robert White contends, but with no supporting data, that if any form of fetal tissue donation is allowed, commercialization is inevitable.²⁶

Mahowald, Silver, and Ratcheson²⁷ have noted that the situation is less ethically secure than the case of surrogate motherhood in that the pregnancy produces only a good effect in the case of surrogate motherhood (i.e., the donation of a baby to an infertile couple), while in the case of pregnancy for organ transplant both good effects (the transplant) and bad effects (the demise of the fetus) are produced. One might observe, however, that there is an additional "bad outcome" in all cases of surrogate motherhood, whether for donating tissue or a living child. Behavioral biologists have taught us much about the phenomenon of "bonding" in recent years, especially about the strength of the bonding that occurs in the antenatum and peripartum periods of the maternal-child relationship. If we accept this biology, then a systematic "bad outcome" occurs in every case of surrogate motherhood, i.e. the intentional creation and destruction of the maternal-child bonding relationship.

5) The 1975 NIH guidelines regarding fetal *research* are sufficient moral grounds for deciding whether or not fetal tissue *transplantation* is justified.

The existing NIH guidelines direct that nontherapeutic research on the living, nonviable fetus can proceed provided that the vital functions are not artificially maintained in order to prolong the dying of the fetus, that no procedures be performed which directly terminate the life of the fetus, and that there are no other means of obtaining the information sought by the research.²⁸ Fletcher and Schulman²⁹ are aware that many

²³ Lewin, n. 19 above.

²⁴ Mary Mahowald et al., "Transplantation of Neural Tissue from Fetuses," [letter] *Science* 235 (1987) 1307-8.

²⁵ Fine, n. 8 above.

²⁶ Robert White, "The Aborted Fetus: A Commercial Prize?" *America* 158, no. 3 (1988) 53-54.

²⁷ Mahowald, Silver, and Ratcheson, n. 15 above.

²⁸ King and Areen, no. 9 above.

²⁹ John D. Fletcher and Joseph D. Schulman, "Fetal Research: The State of the Ques-

currently contemplated research projects involving the nonviable, living, ex-utero fetus could not be performed under the existing guidelines. They have argued that the guidelines should be changed to allow for such types of important research. It seems clear that in order to obtain the maximal amount of viable tissue, some scientists contemplate maintaining the vital functions of the fetus artificially. This clearly violates the present guidelines. Even if the fetus were not artificially maintained, the removal of significant amounts of brain tissue would constitute a direct act of killing an as yet living (though nonviable) fetus. This would also violate the present guidelines. Existing guidelines would therefore need to be altered in order to conduct this type of transplant, even if the current moratorium on nontherapeutic fetal research were to be discontinued. Does the importance of the research constitute sufficient grounds for electing to change the current NIH guidelines?

Are alternative means available? It is conceivable that sufficient tissue could be obtained from dead fetuses after induced abortions or from spontaneous abortions and stillbirths. The yield of viable cells is lower than with live fetuses, but researchers in Mexico have recently performed a successful human transplant using material from a spontaneously aborted fetus.³⁰ Nonfetal tissues might also be effective. The alternatives include the techniques of transplanting the patient's own adrenal cells (even though the results are not as good as in using fetal nerve cells³¹), or the use of cells in tissue culture.³² Further, it is unclear whether or not the results obtained in the transplant experiments are due to a chemical produced by transplanted cells. Such a chemical, if it exists, could be identified, purified, and injected.³³ While these other techniques are not fully developed, it seems that one cannot justify the use of fetal tissue exclusively on the grounds that all alternatives have been exhausted.

Can a position in favor of some use of fetal tissue for transplant be held by persons working within the Catholic tradition? The answer is yes, although a number of limitations would need to be placed upon such research.

First, we should remind ourselves of what Kelly wrote in the 1950s. Since a human being "is only the administrator of his life, and bodily

tion," *Hastings Center Report* 15, no. 2 (1985) 6-12.

³⁰ Madrazo et al., n. 7 above.

³¹ Efraim Azmitia et al., "Cell and Tissue Transplantation into the Adult Brain: Final Discussion," *Annals of the New York Academy of Science* 495 (1987) 676-86.

³² *Ibid.*; Sladek and Gash, n. 3 above.

³³ Sladek, Redmond, and Roth, no. 4 above.

members, and functions, his power to dispose of these things is limited."³⁴ Ought implies can, but can does not imply ought. Our ability to transplant fetal tissue into the brain of a Parkinsonian patient, however wonderful, does not imply that we ought to do so.

Second, our argument can proceed from even the most cautious position, in keeping with the Vatican Instruction, that the dead fetus resulting from an induced abortion was the innocent human victim of an unjustifiable killing, and deserves all the respect due the remains of any deceased member of the human community.³⁵ If the fetus is actually dead, even as the result of an illegitimate abortion, the fetus has the moral status of a human cadaver. The moral permissibility of organ donation from a cadaveric source has been previously established.³⁶ An adult who has been murdered can morally be the source of donated organs. So too can the dead fetus, even if one considers that fetus a victim of murder.

Third, we should follow the "principle of equality" between fetuses going to term and fetuses to be aborted, not allowing either to be treated differently.³⁷ We do not permit, as Andre Hellegers pointed out, the removal of vital unpaired organs from a living adult donor or from a fetus we intend to bring to term. We should therefore not allow the removal of vital brain tissue (which would be a direct act of killing) from the living, ex-utero fetus even if it is nonviable.³⁸ This would mean that the present NIH guidelines for fetal research, which are based on this principle of equality and prohibit any direct act of killing the fetus, should be applied to the case of fetal transplantation.

Several problems arise. How does one determine death in the living but nonviable ex-utero fetus? If the amount of fetal tissue obtained is high enough for successful transplantation using standard criteria of fetal death (absence of fetal heartbeat, respiration, umbilical cord pulse, and spontaneous movement³⁹), such criteria will be sufficient. If not, Hellegers pointed out that since brain waves are present in the fetus at eight weeks, the absence of brain waves at 11–12 weeks could be used to establish fetal death.⁴⁰ Robert White points out the irony of declaring a person "brain dead" and then proceeding to collect living brain cells for

³⁴ Gerald Kelly, *Medico-Moral Problems* (St. Louis: Catholic Hospital Association, 1957) 247.

³⁵ Cf. n. 14 above.

³⁶ Kelly, *Medico-Moral Problems* 245–54.

³⁷ Jonsen, n. 12 above.

³⁸ Andre Hellegers, "Using the Fetus after Abortion," *Ob. Gyn. News*, May 15, 1974, 38.

³⁹ LeRoy Walters, "Ethical Issues in Fetal Research: A Look Back and a Look Forward," *Clinical Research* 36, no. 3 (1988) 209–14.

⁴⁰ Hellegers, n. 38 above.

transplant.⁴¹ But the same reasoning that leads one to adopt a principle of totality for a living human organism⁴² may be used to conclude that a brain cell can still be alive while the brain, qua brain, is not. Therefore it seems that establishing fetal death is technically and philosophically possible.

The thorny problem of consent remains. McCormick argues that the "best interests" of one unable to give consent can be construed by proxy to include the charitable act of consent to research.⁴³ It seems appropriate to apply this communitarian approach here. The difficulty comes, however, in deciding who is the proper proxy. Are the parents who gave consent for the abortion to be understood to represent the "best interests" of the fetus? Mahowald, Silver, and Ratcheson have applied the principle of double effect to the "legitimate" abortion situation and have concluded that the death of the fetus can sometimes be an "unintended" outcome of an abortion performed for other reasons (e.g., the health of the mother).⁴⁴ Therefore they tentatively conclude that in certain cases the mother can still be considered capable of deciding in the "best interests" of the fetus she elects to abort. This seems to be a capricious use of the principle of double effect and threatens the integrity of this important principle. A true "double effect" situation presupposes the overlap, but not the identity, of the desired and the undesired outcomes. One must be realistically able to intend one without intending the other. For example, the pain-relieving and the respiratory-depressant effects of morphine overlap, but they are not completely coextensive pharmacologic effects. One may legitimately strive to give pain relief without killing the patient when using morphine, even though the drug may actually hasten death. One cannot electively abort a fetus without intending the abortion of the fetus. The "undesired" outcome is the very means of producing the desired outcome. This is not to say that it is impossible to mount an argument for some form of "legitimate abortion," but rather to suggest that a double-effect argument cannot be used to establish the case. Nor is such an argument sufficient to establish that a woman who seeks an abortion, even with the best of intentions, can be construed to act in the "best interests" of the fetus and give proxy consent for transplantation

⁴¹ White, n. 26 above.

⁴² B. M. Ashley and K. D. O'Rourke, *Health Care Ethics: A Theological Analysis* (St. Louis: Catholic Hospital Association, 1977) 311-15.

⁴³ McCormick, *How Brave a New World?* 75-78.

⁴⁴ Mahowald, Silver, and Ratcheson, n. 15 above. Mahowald subsequently adopted a more cautious approach and wrote: "Unless the fetus is aborted spontaneously, the proxy should be someone other than the woman who aborted the fetus" (Mary Mahowald, "Placing Wedges along a Slippery Slope: Use of Fetal Tissue for Transplantation," *Clinical Research* 36, no. 3 [1988] 220-22).

of fetal tissue.

Can the fetus then be considered the ward of the state, and can the state therefore act as proxy? The French assume consent for adult organ donation⁴⁵ and the British even assume consent for organ donation by children⁴⁶ unless there is a documented prior objection or a parental veto. One must wonder, however, in the case of induced abortion, whether the state which has allowed the killing of the fetus may be construed as a legitimate guardian acting in the best interests of the fetus. In the U.S., under current federal law, parents can give consent for the use of tissue from electively aborted fetuses which are dead, except as restricted by several of the states.⁴⁷

The most cautious authors maintain that since there is no one who can effectively represent the electively aborted fetus, no electively aborted fetus, alive or dead, should be used for research or transplant. Even this position does not exclude the use of tissue from spontaneously aborted fetuses or stillborns. But in addition, as Arthur Caplan has suggested,⁴⁸ a committee of third parties not related to the parents, the medical staff, or the local Institutional Review Board might act as proxies in the case of the electively aborted fetus. This bypasses concerns about the ironies of proxy consent by the parents or the state. One could allow the parents the opportunity to veto such use of the fetus, but not to give active consent. Accepting a transplant under these conditions would be no more an act of approval of abortion than accepting a liver transplant from the body of a murdered man is an act of approval of murder.

Finally, it would seem prudent to prohibit compensation for any tissue obtained,⁴⁹ to preserve the anonymity of donor and recipient, and to prohibit the surgeon who will perform the transplant from acting as the physician who declares the fetus dead.⁵⁰ Under these conditions it seems then that even a cautious moralist could accept a transplant of nerve tissue from a dead fetus, if the parents of a stillborn or spontaneously aborted fetus have given permission or if some disinterested party other than the parents or the state has assumed responsibility for the remains of an electively aborted fetus and has given appropriate consent.

⁴⁵ Andrew C. Varga, *The Main Issues in Bioethics* (New York: Paulist, 1980) 147–48. The French National Ethical Committee, however, proscribes the use of living fetuses: see LeRoy Walters, n. 39 above.

⁴⁶ Ramsey, *Ethics of Fetal Research* 88–89.

⁴⁷ King and Areen, n. 39 above.

⁴⁸ Caplan, n. 20 above.

⁴⁹ Ashley and O'Rourke, *Health Care Ethics* 378.

⁵⁰ Mahowald, "Placing Wedges" (n. 44 above).

AIDS AND THE MORAL RESPONSIBILITIES OF PHYSICIANS

The Acquired Immunodeficiency Syndrome (AIDS) is a new disease. The first cases of AIDS and the AIDS-related complex (ARC) were reported in 1981.⁵¹ The Human Immunodeficiency Virus (HIV) which causes the disease was discovered in 1983.⁵² Infection with HIV causes susceptibility to certain cancers and to a host of other infections. HIV infection causes damage to the brain, the peripheral nervous system, the blood cells, the skin, and almost every organ in the body. While some drug therapies appear to be able to slow the progress of the disease, and while most of the infections caused by the immunodeficient state can be successfully treated, the disease itself is currently incurable.

A new and lethal disease like AIDS raises many questions. Given the fact that the major risk factors in the U.S. for contracting AIDS are homosexual intercourse and intravenous drug use, many of the moral questions which surface relate to the morality of these activities and to prevailing social attitudes. In a recent article in this journal, Spohn has comprehensively outlined many of these questions.⁵³

The AIDS epidemic raises, however, another set of questions. Is this epidemic "bringing out the best in medicine"⁵⁴ or has it exposed the profession's moral malaise?⁵⁵ Journalists have documented the reluctance of many physicians to treat HIV-infected patients.⁵⁶ Medical-journal articles report cases of individuals who have refused to provide such care,⁵⁷ and have printed letters and articles defending the morality of the decision to refuse to care for HIV-infected patients.⁵⁸ In contrast, the American College of Physicians and the American Medical Association have both termed the care of HIV-infected patients a "duty" for physi-

⁵¹ "Pneumocystis Pneumonia—Los Angeles," *Morbidity and Mortality Weekly Report* 30 (1981) 250.

⁵² F. Barre-Sinoussi et al., "Isolation of a T-lymphotropic Virus from a Patient at Risk for the Acquired Immunodeficiency Syndrome (AIDS)," *Science* 220 (1983) 868–71; Robert C. Gallo et al., "Frequent Isolation and Detection of Cytopathic Retroviruses from Patients with AIDS and at Risk for AIDS," *ibid.* 224 (1984) 500–503.

⁵³ William C. Spohn, S.J., "The Moral Dimensions of AIDS," *TS* 49 (1988) 89–109.

⁵⁴ Kevin M. Cahill, "AIDS: Medical Reflections," *America* 154, no. 24 (1986) 507–8, 517.

⁵⁵ Richard A. McCormick, S.J., "AIDS: The Shape of the Ethical Challenge," *America* 158, no. 6 (1988) 147–54.

⁵⁶ M. Clark, J. Huck, V. Quade, and M. Canton, "Doctors Fear AIDS, Too," *Newsweek*, Aug. 3, 1987, 58–59.

⁵⁷ Robert Steinbrook, Bernard Lo, et al., "Ethical Dilemmas in Caring for Patients with the Acquired Immunodeficiency Syndrome," *Annals of Internal Medicine* 103 (1986) 1127–32.

⁵⁸ Jeffrey D. Tiemstra, *Journal of the American Medical Association* (letter) 259, no. 4 (1988) 517 (hereafter *JAMA*); Peter J. Guy, "AIDS: A Doctor's Duty," *British Medical Journal* 294 (1987) 445.

cians.⁵⁹ The AMA leaves a loophole, however. "Physicians who are unable to provide the services required by AIDS patients should make referrals to those physicians or facilities equipped to provide such services." Moreover, the AMA does not intend to *enforce* any duty to treat HIV-positive patients.⁶⁰

Health-care workers who refuse to treat HIV-positive patients often cite personal risk as the reason for their refusal. How great is the risk? While the data are a matter of controversy, it seems that the risk of being infected with the AIDS virus is between 1 in 400 and 1 in 800 per recognized penetrating needle-stick injury.⁶¹ Given the relative infrequency of needle-stick injuries per year for internists, this is approximately the same as the risk of death per year for a Boston fire fighter.⁶² The risks associated with casual exposure seem negligible.⁶³ Some critics have attacked this research as "advocate science," charging that such studies begin with a social point of view and are designed to prove that point.⁶⁴ Yet multiple investigators have reached the same conclusions regarding the relatively low risk of infection.⁶⁵ While the scientific investigation of AIDS may be incomplete, we cannot ignore the information we already have,⁶⁶ and we cannot postpone action on behalf of

⁵⁹ Health and Public Policy Committee of the American College of Physicians and the Infectious Diseases Society of America, "The Acquired Immunodeficiency Syndrome," *Annals of Internal Medicine* 104 (1986) 575-81; Report of the AMA's Council on Ethical and Judicial Affairs, "Ethical Issues Involved in the Growing AIDS Crisis," *JAMA* 259, no. 9 (1988) 1360-61.

⁶⁰ George G. Annas, "Not Saints, but Healers: The Legal Duties of Health Care Professionals in the AIDS Epidemic," *American Journal of Public Health* 78, no. 7 (1988) 844-49.

⁶¹ E. McCray, "Occupational Risk of the Acquired Immunodeficiency Syndrome among Health Care Workers," *NEJM* 314 (1986) 1127-32; D. K. Henderson et al., "Risk of Nosocomial Infection with Human T-cell Lymphotropic Virus Type III/Lymphadenopathy Associated Virus in a Large Cohort of Intensively Exposed Health Care Workers," *Annals of Internal Medicine* 104 (1986) 644-47.

⁶² Ezekial J. Emanuel, "Do Physicians Have an Obligation to Treat Patients with AIDS?" *NEJM* 318 (1988) 1686-90.

⁶³ Alan R. Lifson, "Do Alternative Modes for Transmission of the Human Immunodeficiency Virus Exist?" *JAMA* 259, no. 9 (1988) 1353-56; Kenneth G. Castro et al., "Investigation of AIDS Patients with No Previously Identified Risk Factors," *ibid.* 259, no. 9 (1988) 1338-42.

⁶⁴ Eugene F. Diamond, "AIDS and Advocate Science," *Linacre Quarterly* 54, no. 4 (1987) 50-54.

⁶⁵ Gerald H. Friedland and Robert S. Klein, "Transmission of the Human Immunodeficiency Virus," *NEJM* 317 (1987) 1125-35; James R. Allen, "Health Care Workers and the Risk of HIV Transmission," *Hastings Center Report* 18, supplement (April/May 1988) 2-5.

⁶⁶ Jerome Kim and John Perfect, "To Help the Sick: An Historical and Ethical Essay concerning the Refusal to Care for Patients with AIDS," *American Journal of Medicine* 84 (1988) 135-38.

such seriously ill persons merely because our knowledge is only probable.

Is some degree of altruism required of physicians? If so, should this be enforced? If it is to be enforced, how should the enforcement be accomplished? These are significant questions brought to public discussion by the discovery of the new and lethal disease caused by the Human Immunodeficiency Virus.

Some have argued that altruism is not required of physicians. "Since the Hippocratic Oath, physicians have been seen to verge on making the supererogatory the obligatory. But this must be a religious (or quasi-religious) decision of the physician, one made without coercion."⁶⁷ The AMA codes once emphasized a duty to treat all patients, but since 1912 they have emphasized the freedom of physicians. The most recent AMA Code of Ethics states that except in emergencies, physicians shall be "free to choose whom to serve."⁶⁸

Some have stated that there is no duty to care for AIDS patients because "no one can require self-sacrifice for hopeless cases."⁶⁹ Emanuel⁷⁰ has pointed out that such reasoning can only be applied meaningfully to cases of completely inessential care, such as cosmetic surgery for AIDS patients, where the benefits to the patient are trivial and even a small risk to the practitioner would seem disproportionate. AIDS is not hopeless, however. First, HIV infection is peculiar because it is an incurable infection that causes many curable infections along the way. And while drugs like zidovudine (AZT) cannot cure AIDS, they can slow its course. Therefore the disease is not, in a purely medical sense, hopeless. Second, the case can be made that no disease, even if it is incurable, is truly "hopeless." Curing, in the strict physiological sense, is only one of the goals of medicine. An anonymous 15th-century saying summarizes these goals: "To cure sometimes, to relieve often, and to comfort always." For a physician to refuse to care for the dying because he or she cannot effect a physiological cure for the disease is to neglect the goals of medicine and to cease to be a genuine healer.

LeRoy Walters writes that requiring physicians to take significant risks in caring for patients "would violate both the principles of autonomy and beneficence."⁷¹ He seems to imply that the broadly accepted medico-moral principles of beneficence and autonomy are to be applied to the

⁶⁷ Michael LeChat, "Some Ethical Reflections on AIDS," *Linacre Quarterly* 53, no. 3 (1988) 56-69.

⁶⁸ Abigail Zuger and Steven H. Miles, "Physicians, AIDS, and Occupational Risk," *JAMA* 248, no. 14 (1987) 1924-28.

⁶⁹ LeChat, n. 67 above.

⁷⁰ Emanuel, n. 62 above.

⁷¹ LeRoy Walters, "Ethical Issues in the Prevention and Treatment of HIV Infection and AIDS," *Science* 239 (1988) 597-603.

practitioner as well as to the patient. Was the aphorism *primum non nocere* ever intended for application to the physician? If we interpret this in a rigidly deontologic fashion, we could never require a physician to accept even minor inconveniences in caring for patients. If we interpret this as a prima-facie rule, then every inconvenience for the physician becomes a matter of dispute, not a moral and professional expectation. If we adopt a utilitarian basis for deciding whether or not to require physicians to accept inconveniences or risks, then we must perform a calculation of the net beneficence to patients and to providers. Left open is the possibility of an argument by a physician that the benefit to self, plus the foreseen benefit he or she expects to provide to family and to future patients, justifies a policy of not accepting the inconveniences or risks of caring for certain patients or types of patients. Do we want the care of individual patients to be directed by this sort of analysis?

Other variations on this theme can be advanced. One might argue that being fearful, or angry, would only compromise the care one would provide for HIV-infected patients and that therefore one should not treat such patients.⁷² Pellegrino has also reported that some physicians, who see the doctor-patient relationship in contractual terms, argue that "AIDS wasn't in the contract" when they entered the profession, and that since nature has broken the contract, they see no obligation to treat such patients.⁷³

Interns and residents bear a disproportionate burden of exposure to HIV-infected blood and body fluids. The ethicists, public-health officials, and professors of medicine who champion the duty to treat HIV-infected patients generally do not have a very intense exposure to infected blood and body fluids. This fact has been sensitively pointed out by several authors.⁷⁴ While this may be true, young physicians should note that each generation of physicians has taken its oath and has entered the profession open to the future and exposed to risks not encountered by their professors, who were the young physicians of the previous generation. The last generation of physicians risked tuberculosis and hepatitis B. AIDS is simply the stark truth of medicine today.

The "historical and ethical precedents are inconsistent" regarding the

⁷² Joseph M. Healey, "Is There a Duty to Treat AIDS Patients?" *Connecticut Medicine* 52, no. 3 (1988) 187.

⁷³ Edmund D. Pellegrino, "Altruism, Self-Interest, and Medical Ethics," *JAMA* 258, no. 14 (1987) 1939-40.

⁷⁴ Abigail Zuger, "AIDS on the Wards: A Residency in Medical Ethics," *Hastings Center Report* 17, no. 3 (June 1987) 16-20; Steinbrook, Lo, et al., n. 57 above.

degree of altruism which can be required of physicians.⁷⁵ But there is a clear lineage of writers who from antiquity to the present have held that medical practice requires a degree of self-effacement. In the first century A.D., for example, Scribonius Largus, writing about medicine with such strong words as *professio*, *misericordia*, *humanitas*, and *sacramentum*, clearly argued for a significant degree of self-effacement on the part of the physician.⁷⁶ In the 20th century, Abraham Flexner, the great reformer of American medical education, included altruism among the characteristics which define a profession.⁷⁷ Are these authors correct? And if so, what should be the appropriate response of physicians facing the AIDS epidemic?

The American bishops' statement on AIDS does not seem to allow health-care workers any moral grounds for refusing to care for HIV-infected patients.⁷⁸ While the document has stirred controversy among the bishops over other issues, this point has not proven problematic. An editorial in *America* made an even stronger statement: "To shun an AIDS victim is to shun Christ. Catholic hospitals, hospices, chaplains, doctors, and other personnel have a special responsibility for the care of AIDS victims."⁷⁹

On becoming a physician, does one take on a special obligation to benefit one's patients "which is greater than the ordinary obligations we all have to benefit one another"?⁸⁰ While many have vigorously made this claim, only Pellegrino and Thomasma⁸¹ have delineated reasons which support the notion that altruism is intrinsic to medicine. Their argument is based on three facts about medicine from which they infer that a degree of altruism is obligatory for physicians. First, the vulnerability of the sick patient necessitates a relationship of trust when a physician offers to put knowledge at the service of the sick. Second, the

⁷⁵ Pellegrino, n. 73 above; Daniel M. Fox, "The Politics of Physicians; Responsibility in Epidemics: A Note on History," *Hastings Center Report* 18, supplement (April/May 1988) 5-10.

⁷⁶ Edmund D. Pellegrino and Alice A. Pellegrino, "Humanism and Ethics in Roman Medicine: Translation and Commentary on a Text of Scribonius Largus," presented before the Washington Society for the History of Medicine, April 30, 1983, and the Osler Medical Society, Minneapolis, May 3, 1983.

⁷⁷ Abraham Flexner, "Is Social Work a Profession?" *School and Society* 1 (1915) 901-11.

⁷⁸ United States Catholic Conference Administrative Board, "The Many Faces of AIDS: A Gospel Response," *Origins* 17, no. 28 (1987) 481-89.

⁷⁹ Editorial, "AIDS: A Christian Response," *America* 153, no. 4 (Aug. 17-24, 1985) 77.

⁸⁰ Raanan Gillon, "Refusal to Treat AIDS and HIV Positive Patients," *British Medical Journal* 294, no. 6583 (1987) 1332-33.

⁸¹ Edmund D. Pellegrino and David C. Thomasma, *For the Patient's Good: The Restoration of Beneficence in Health Care* (New York: Oxford University, 1988); Pellegrino, n. 73 above.

knowledge of the physician is nonproprietary. Society has offered the bodies of its living to experimentation and the bodies of its dead to dissection. The huge pool of medical knowledge is shared by a global community of practitioners and is an expanding, self-correcting process of learning which belongs to no one physician. Society even financially subsidizes the education of all physicians in this country. Third, all physicians, on entering the profession, take an oath of some sort by which each publicly promises to serve the interests of the sick. On the basis of these facts, Pellegrino and Thomasma infer an obligation of self-effacement on the part of physicians which requires that they care for HIV-infected patients despite the fact that this entails a degree of personal risk.

If one accepts this proposition that the relationship between doctor and patient is "special" and requires "special" obligations on the part of the doctor, one must still address the question of competing "special" relationships such as the relationship to family. Meilaender⁸² has pointed out that while the vulnerability of the patient results in a prima-facie duty to help, this must be tempered by obligations to others and to self-preservation. Consider, for example, the risks taken on by a pregnant surgeon, who has a high risk of penetrating injury and has special obligations to her family and to her unborn child. What degree of altruism can we expect of her? Emanuel agrees with Meilaender and concludes that obligations to family can override obligations to patients.⁸³ But where the line can be drawn is unclear.

Is an appeal to the virtue of physicians sufficient?⁸⁴ Is it true that every plague "will inevitably produce a two-tiered system of care-givers"?⁸⁵ Some propose that physicians be *required* to care for AIDS patients. Others say it is a commendable option which should be chosen by those who are virtuous. Should we, as some have done, sigh with a sense of resignation and quote Gibbon: "The same passions which made these regulations necessary rendered them ineffectual"?⁸⁶ Or should we, recognizing Pellegrino's observation that virtue "is always a scarce commodity," conclude that "it is the conception that altruism is non-obligatory that is erroneous"?⁸⁷ Are those physicians and ethicists who demand that all physicians accept the risks of caring for AIDS patients merely

⁸² Gilbert Meilaender, "Morality in Plague Time: AIDS in Theological Perspective," *Linacre Quarterly* 55, no. 3 (1988) 11-42.

⁸³ Emanuel, no. 62 above.

⁸⁴ John D. Arras, "The Fragile Web of Responsibility: AIDS and the Duty to Treat," *Hastings Center Report* 18, supplement (April/May 1988) 10-20.

⁸⁵ Meilaender, no. 82 above.

⁸⁶ Kim and Perfect, n. 66 above.

⁸⁷ Pellegrino, n. 73 above.

modern-day Donatists, demanding that those who would not be martyrs be excluded from their ranks?⁸⁸ These are difficult and important questions.

No less important is the question of how one would enforce such a duty. The law defines the relationship between doctor and patient in contractual, not covenantal, terms. This has suggested to at least one physician that, like any other contractual relationship, "the physician, like the patient, can terminate that relationship (reasonably) or refuse to enter into it."⁸⁹ No physician may abandon a patient once this contract has been initiated, but before taking on a patient's case, the law allows a physician to refuse to treat nonemergency conditions. If our society keenly wishes to enforce a duty to treat AIDS patients, however, there are legal options available. States may, for instance, wish to follow the example of New Jersey and require physicians to treat AIDS patients as a condition for licensing.⁹⁰

The risk of acquiring HIV infection while caring for the sick is real, but it is not prohibitive. Those who care for HIV-infected patients are courting neither suicide nor martyrdom. They are simply doing what is theirs to do. "Society could not tolerate firemen and policemen who refused ever to risk their lives in doing their jobs. Nor need it tolerate health care professionals who refuse to take risks to do theirs."⁹¹ The uniqueness of the doctor-patient relationship requires a degree of self-effacement on the part of physicians which is at least as strong as the degree of obligation required of policemen and firemen. All such persons have other "special" relationships with competing obligations such as those to spouse and family. The choice such persons face is a genuine ethical dilemma: a choice between conflicting special duties. Tragically but heroically, they must ask their families and friends to share in the risks of their jobs. Prudence dictates that there may be exceptions, such as the pregnant surgeon who, in addition to her personal risk, temporarily puts her voiceless fetus at risk as well. Prudence also dictates that physicians use all reasonable precautions available to minimize personal risk. But some degree of self-effacement is part of the meaning of being

⁸⁸ Henry Chadwick, *The Early Church* (Grand Rapids: Erdmans, 1967) 219–25.

⁸⁹ Tiemstra, n. 58 above.

⁹⁰ For very lucid discussions of the medico-legal aspects of the AIDS epidemic, see George G. Annas, "Legal Risks and Responsibilities of Physicians in the AIDS Epidemic," *Hastings Center Report* 18, supplement (April/May 1988) 26–32; *idem.*, n. 60 above; Joseph M. Healey, "Is There a Duty to Treat AIDS Patients," *Connecticut Medicine* 52, no. 3 (1988) 187; *idem.*, "The Duty to Treat AIDS Patients: Ethical and Legal Perspectives," *ibid.* 52, no. 4 (1988) 249; *idem.*, "Treating AIDS Patients: Clarifying the Physician's Duties," *ibid.* 52, no. 5 (1988) 315.

⁹¹ Annas, n. 60 above.

a policeman or a doctor. Those who cannot accept this should find another way to earn their bread.

MORALITY AND THE HEALTH-MAINTENANCE ORGANIZATION

The total U.S. health-care bill is in excess of one billion dollars a day.⁹² In facing such a staggering figure, the response of economists has been to apply the algorithms of cost-benefit analysis and to say that "treatments must be stopped when marginal benefits equal marginal costs."⁹³

Under such intense economic pressure, both private insurance companies and the government (through Medicaid and Medicare) have introduced cost-saving plans. Among the many means by which private insurers and the government propose to decrease health-care expenditures, their promotion of the health-maintenance organization (HMO) is one that is undergoing significant ethical scrutiny.

By 1987 the number of Americans enrolled in HMOs had reached 27 million. Nearly half were enrolled in for-profit plans.⁹⁴ It has been a widely accepted assumption that HMOs would result in decreased medical-care costs, primarily by reducing patient hospitalization and elective surgery.⁹⁵ In addition, it has been advocated for some time that by explicitly making medical care a free-enterprise commodity subject to market competition, care would be delivered more efficiently and more inexpensively.⁹⁶

The milieu in which medicine is practiced has certainly changed in the U.S. in the last several decades. The simple, unilateral doctor-patient relationship has been replaced by a multilateral relationship involving the employers of both the doctor and the patient, the insurers of both the doctor and the patient, the lawyers of both the doctor and the patient, and the federal, state, and local governments. This is especially true in an HMO, where many of these relationships and their sometimes incongruent interests are more explicit. The question of moral concern is whether or not the HMO has brought the interests of the patient and the physician into direct conflict.⁹⁷

⁹² Pellegrino and Thomasma, *For the Patient's Good* 183.

⁹³ Michael D. Reagan, "Physicians as Gatekeepers: An Ethical Challenge," *NEJM* 317 (1987) 1731-34.

⁹⁴ Douglas F. Levinson, "Towards Full Disclosure of Referral Restrictions and Financial Incentives by Prepaid Health Plans," *NEJM* 317 (1987) 1729-31.

⁹⁵ Gail Povar and Jonathan Moreno, "Hippocrates and the Health Maintenance Organization," *Annals of Internal Medicine* 109 (1988) 419-24.

⁹⁶ Milton Friedmam, *Capitalism and Freedom* (Chicago: Univ. of Chicago, 1962) 149-60; Eli Ginzberg, "For-Profit Medicine: A Reassessment," *NEJM* 319 (1988) 757-61.

⁹⁷ Alan L. Hillman, "Financial Incentives for Physicians in HMO's: Is There a Conflict of Interest?" *NEJM* 317 (1987) 1743-48.

Primary-care physicians have always been the mode of access for patients to the full range of services available in the health-care system. It is the physician who orders the tests and prescribes the treatments. Pellegrino and Thomasma have called this "de-facto" gatekeeping.⁹⁸ The HMO has promoted another variation on gatekeeping, however, which Pellegrino and Thomasma have dubbed "negative gatekeeping"⁹⁹ and which has become widely accepted as a matter-of-fact reality for American medical practice.¹⁰⁰ Negative gatekeeping refers to the system of incentives by which a physician is urged to reduce utilization of tests, surgery, specialty referrals, and hospitalization. Negative gatekeeping has the advantage of reducing unnecessary medical interventions with their attendant risks of side effects and financial costs. It has aroused the suspicion of many physicians, however,¹⁰¹ since it has the potential to promote a conflict of interest in which it is to the physician's personal financial benefit to limit services in delivering care to his or her patients.

The moral questions raised by the HMO have been addressed from several distinct points of view. In the remainder of this paper three of these points of view will be presented, and these points of view will then be critiqued from the viewpoint of the concerned practicing physician. The first point of view is that of the libertarian; the second, that of the politically liberal health-policy analyst; the third, the Marxist perspective. The critique will be based on the views of Pellegrino and Thomasma.¹⁰²

The libertarian perspective takes it as axiomatic "that freedom of choice is valued more highly than equality of outcome and that our commitments to beneficence are limited."¹⁰³ The libertarian notes the great historical controversies over physicians' fees and other medico-economic concerns, and concludes that "it should come as no surprise that medicine as a cottage industry was practiced at least partly for

⁹⁸ Pellegrino and Thomasma, *For the Patient's Good* 174-75.

⁹⁹ *Ibid.* 176.

¹⁰⁰ John M. Eisenberg, "The Internist as Gatekeeper: Preparing the General Internist for a New Role," *Annals of Internal Medicine* 102 (1985) 537-43; Howard Brody, "Ethical Gatekeeping: The Ongoing Debate," *Journal of Family Practice* 23, no. 6 (1986) 539-40; Katherine A. Hesse, Sue E. Levkoff, and Edward W. Campion, "House Officer's Knowledge of Geriatric Health Policy: Are the Gatekeepers Learning the Rules?" *Gerontologist* 28, no. 2 (1988) 233-36.

¹⁰¹ Henry Scovern, "Hired Help: A Physician's Experiences in a For-Profit Staff Model HMO," *NEJM* 319 (1988) 787-90; Steven Swiryn, "The Doctor as Gatekeeper," *Archives of Internal Medicine* 146 (1986) 1789; Arthur E. Cocco, "Gatekeeper," *Maryland Medical Journal* 35, no. 4 (1986) 273-76.

¹⁰² Pellegrino and Thomasma, *For the Patient's Good* 172-89.

¹⁰³ H. Tristram Engelhardt and Michael A. Rie, "Morality for the Medical-Industrial Complex," *NEJM* 319 (1988) 1086-89.

profit. Nor is this itself evil. Medicine is not an endeavor of amateurs nor usually of mendicant friars.¹⁰⁴ The libertarian accepts the fact that medicine today has become “deeply entrepreneurial” and believes that the most pressing ethical issue in health-care economics is the question of whether or not the public is better off when health facilities are owned and operated by physicians or by managers without medical training and expertise.¹⁰⁵ They accept the notion that health care is a commodity for sale on the market¹⁰⁶ and believe that “the profit motive should encourage the retailing of virtue because the market is likely to reward corporations that treat patients as individuals.”¹⁰⁷ They do not accept the notion that any more special obligations to care for the poor ought be imposed upon those who retail medical care than the obligations imposed upon those who retail other basic goods like food or shelter.¹⁰⁸ Paying taxes is sufficient social responsibility for proprietary health-care facilities.¹⁰⁹ The practice of “dumping” poor patients from proprietary to nonproprietary facilities by forced transfer and the practice of “skimming” affluent patients and profitable diagnoses off the top of the patient pool are regarded as virtuous practices because they compel “individuals, communities, and governments to confront the question of the level of care they wish to provide for the indigent.”¹¹⁰ In the libertarian view the profit motive in medicine is a moral good, and the for-profit HMO morally praiseworthy.

The politically liberal health-policy analyst takes a different perspective. The health-policy analyst takes rising health-care costs very seriously. The HMO, from this perspective, becomes problematic for society simply because it forces us to make the hard choices we would rather not have to make.¹¹¹ Even “negative gatekeeping” can be seen in its most positive light, decreasing unnecessary procedures and side effects, stimulating a rigorous reappraisal of the utility of our health-care technology, and bringing the medical and social-service aspects of health care into

¹⁰⁴ *Ibid.*; note also that the Association of Sister, Brother, and Priest Physicians includes three mendicant friars among its 136 members.

¹⁰⁵ Richard H. Egdahl and Cynthia H. Taft, “Financial Incentives to Physicians,” *NEJM* 315 (1986) 59–61.

¹⁰⁶ William R. Fifer, “The Medical Staff of 1997,” *Quality Review Bulletin* 13, no. 6 (1987) 194–97.

¹⁰⁷ Engelhardt and Rie, n. 103 above.

¹⁰⁸ Dan W. Brock and Allen E. Buchanan, “The Profit Motive in Medicine,” *Journal of Medicine and Philosophy* 12 (1987) 1–35.

¹⁰⁹ *Ibid.*

¹¹⁰ Engelhardt and Rie, n. 103 above.

¹¹¹ Povar and Moreno, n. 95 above.

conjunction.¹¹² The philosophical foundation of the HMO is based upon three assumptions of the health-policy analyst: that the HMO can control costs, that the HMO can reduce social barriers to primary care and thus result in earlier diagnoses and better outcomes, and that the “negative gatekeeping” functions of the HMO can be constructed in such a way as to avoid “inappropriate underutilization” of medically indicated services.¹¹³ According to the health-policy analysts, peer review of physician performance, “consumer protection” policies, and physician education will prevent underutilization of medically indicated services in the name of profit.¹¹⁴ They note that conflicts of interest are not new to physicians.¹¹⁵ They argue that “consumer protection” for patients is both necessary and long overdue.

Povar and Moreno go one step further than most health-policy analysts in trying to assure an ethically sound basis for the HMO. They argue, from the perspective of public health, for “an ethic of community” in which the institution and its physicians recognize “an obligation to act as advocates for the community of patients who participate in the program and not only for the individual patient.”¹¹⁶ In their vision a community of patients and physicians gather to form an organization in which all share in both the protection of their health and the distribution of costs, fully informed that this will entail a degree of “negative gatekeeping.” In this sense the advocacy of the physician has shifted from the interests of the individual patient to the interests of the community of patients. This ethic of community applies only to the nonprofit HMO. “In for-profit contexts, the potentially problematic incentive structure no longer directly preserves the [interests of the community of patients] . . . , but satisfies parties whose interests are not the health care mission of the HMO per se. Such parties are outside the community on which we have grounded our claim to justice.”¹¹⁷ Thus Povar and Moreno find a moral basis for the HMO only in the nonprofit context, and have prescribed what amounts to a description of the HMO as a “medical kibbutz.”

For the Marxist, this description of the HMO as a “medical kibbutz” does not go far enough. From the Marxist perspective of Himmelstein

¹¹² Reagan, n. 93 above.

¹¹³ Povar and Moreno, n. 95 above.

¹¹⁴ Reagan, n. 93 above.

¹¹⁵ Povar and Moreno, n. 95 above.

¹¹⁶ *Ibid.*

¹¹⁷ *Ibid.*

and Woolhandler, the HMO is merely a “corporate compromise.”¹¹⁸ They see medicine as “one section of the economic production that responds to the economic and political needs of the capitalist system as a whole.” These authors trace the development of American medicine from a “cottage industry,” through a period of trade guilds operating as monopolies under the guise of voluntary hospitals, to the rise of the large proprietary hospital chains and HMOs making huge profits. They see the rising costs of medical care for workers as the stimulus for industry to control all aspects of health care directly, and to “proletarianize” the physician into an employee of the for-profit HMO, linking the physician’s livelihood to his or her talent in discouraging the utilization of health-care services. They see the HMO practice of “skimming” the healthy, wealthy, and more profitable patients as an inevitable development which further disenfranchises the poor from the health-care system. The only possible solution Himmelstein and Woolhandler see is a system of national health insurance, perhaps modeled on the Canadian system. This will be possible only if physicians and patients form a “coalition of forces capable of resisting the imperatives of pecuniary interests.”

Many physicians have objected to the HMO model, often because they resent having been “proletarianized” and shorn of their previous social esteem,¹¹⁹ or because they perceive that their own autonomy is reduced when they become employees.¹²⁰ Neither of these objections is a sufficient ground for an ethical argument against the HMO. The physician must argue, to be credible, on the basis of his or her interest in the good of the patient.¹²¹

One may object to all three of the previous viewpoints because they share a common mistake: all treat health care as a commodity. Brock and Buchanan respond to such objections by arguing that medical care should not be considered any differently than other basic human goods like food and shelter, and that those who provide medical care have no social obligations beyond those required of persons who sell meat and houses.¹²² But medicine is in fact “special,” even when considered in relation to basic human needs like food and shelter. First, the patient is infinitely more vulnerable than the customer who purchases commodities. One need not reveal one’s most personal secrets nor expose one’s

¹¹⁸ David U. Himmelstein and Steffie Woolhandler, “The Corporate Compromise: A Marxist View of Health Maintenance Organizations and Prospective Payment,” *Annals of Internal Medicine* 109 (1988) 494–501.

¹¹⁹ *Ibid.*

¹²⁰ Brock and Buchanan, n. 108 above.

¹²¹ Pellegrino and Thomasma, *For the Patient’s Good* 172–89.

¹²² Brock and Buchanan, n. 108 above.

genitalia to a real-estate agent. The physical effects of being ill compound this vulnerability. The state of the patient who must trust in the care of a physician is unique, and demands obligations on the part of the physician which are not expected of anyone else in society. Second, medical care is profoundly relational. One speaks of a "doctor-patient relationship," and there is even evidence that this relationship is itself therapeutic.¹²³ One does not speak of a "butcher-customer relationship" in such terms. The act of healing with its deeply personal meaning is as much a part of health care as the pill the physician prescribes. Third, illness is an endpoint, superseded only by death. Malnutrition and exposure to the elements can cause disease, but disease does not cause famine or housing shortages. This is not a difference of degree of importance among commodities, but is evidence of a qualitative distinction between medical care and a commodity. It is a mistake to equate medical care with merchandise.

Because this is so, Flexner was able to conclude that "medicine, curative and preventive, has indeed no analogy with business. . . . The medical profession is supported for a benign, not a selfish, for a protective, not an exploiting purpose."¹²⁴ John Paul II has pointed out that it is neither the means of production nor the product but the human being who is the subject of all human labor.¹²⁵ Where is this more profoundly true than in the labor of caring for patients?

One may argue that despite such lofty ideals the facts point out to us that physicians have always practiced with mixed motives. Even when not motivated by the desire for financial reward, there have always been and will continue to be some physicians who have been motivated by the desire for prestige or for power. How does the HMO change any of this?

What the for-profit HMO does which is unique is to *institutionalize* the profit motive and set it systematically in potential conflict with the interests of the patient. In the "fee-for-service" model the health of the individual patient is the stated goal; medical care is the means of achieving that goal; an appeal is made to the physician's altruism; the wages of the physician are determined on the basis of a "just price" established for each encounter; greed and the provision of unnecessary services for the sake of profit are considered deviations from expected behavior and can be punished by social and legal action. In the socialist

¹²³ Anthony L. Suchman and Dale A. Matthews, "What Makes the Patient-Doctor Relationship Therapeutic? Exploring the Connexional Dimension of Medical Care," *Annals of Internal Medicine* 108 (1988) 125-30.

¹²⁴ Abraham Flexner, *Medical Education in the United States and Canada* (Boston: Merrymount, 1910) 173.

¹²⁵ John Paul II, encyclical *Laborem exercens*, *Origins* 11, no. 15 (Sept. 24, 1981) 225-44.

model (whether it is generalized across a nation or operating within a "medical kibbutz") the stated goals are the health of the group and the just distribution of costs; medicine is the means to those ends; the appeal is to altruism; the physician's wages are determined by negotiation with the group for a "just wage," and self-interested behavior is considered a deviation which is prevented from affecting the goals of the group by its laws and structures. In the for-profit HMO the stated goals are the profit of the owner and the delivery of health care to a group of consumers; the means of achieving those goals are the medical care produced and the wages paid; the appeal is precisely to physician self-interest; unprofitable physician behavior becomes a deviation from expectations, and such deviation can result in lower wages or termination of employment. It is one thing to say that there have always been some immoral physicians. The for-profit HMO model seems to accept that all physicians are self-interested and that this self-interest can be exploited for corporate profit.

On three counts, then, it seems that the for-profit HMOs have introduced morally suspect activities into medical care. They have "depersonalized" the doctor-patient relationship, turning it into a commodity for sale on the market; they have ignored the obligation of health-care providers to care for the poor; and they have created a system of negative gatekeeping which has institutionalized self-interest as a motivating force for physicians, setting this in conflict with the physician's primary duty to assure the best interests of the patient. For similar reasons Relman has argued that physicians should not work in HMO settings where there are financial incentives to limit access to care.¹²⁶

If the proprietary HMO is morally unacceptable, is either a system of *nonprofit* HMOs or a national system of socialized medicine an acceptable moral alternative to the fee-for-service system? The answer is probably yes, although one must be aware that these systems also raise their own moral questions. Catholic health-care institutions, whether operating within a capitalist or a socialist society, must "rest uneasy until the poor are served."¹²⁷ Some mount an argument for socialized medicine or for nonprofit HMOs as the best means of providing care for the poor based on an "ethic of community."¹²⁸ Others argue for such systems based on their perception of an acute need for economic rationing. It does not seem, however, that our wealthy nation is experiencing such economic distress that we meet the criteria for moral rationing which Pellegrino

¹²⁶ Arnold S. Relman, "Salaried Physicians and Economic Incentives," *NEJM* 319 (1988) 784.

¹²⁷ Richard A. McCormick, *Health and Medicine in the Catholic Tradition* (New York: Crossroad, 1987) 79.

¹²⁸ Povar and Moreno, n. 95 above.

and Thomasma have outlined.¹²⁹ The poor can and ought to be served.

Yet one must be careful to note what it means to shift from an ethic of caring for individual patients to an ethic of caring for a group of patients. Such an ethical shift must inevitably accompany the move to the nonprofit HMO or to socialized medicine. One must realize that it is extraordinarily difficult to provide simultaneously for the good of the individual patient and also to assure equal access to all.¹³⁰ Patients do not "generally expect the physician to be an instrument of social and economic policy."¹³¹ One should also be wary that Marxist approaches, while praiseworthy for their egalitarianism, tend nonetheless to regard health care as a commodity. As John Paul II has noted, both capitalist materialism and dialectical materialism "fail to recognize the primacy of the person over things."¹³² Despite these caveats, it seems that nonprofit HMOs or a generalized national system of socialized medicine would be morally preferable to a system of proprietary HMOs.

CONCLUSION

Each of our three areas illustrates a way in which new issues in medical morality emerge: the propriety of new techniques can be questioned, new diseases may appear and raise new questions, or the social milieu in which medicine is practiced can change and introduce new questions. Each of these issues, while "new" in one sense, has forced us to look at other questions which are really quite "old." Fetal transplantation raises questions about abortion, transplantation, fetal experimentation, the meaning of personhood, the meaning of consent. AIDS raises very old questions about the nature of the doctor-patient relationship, what it means to be sick, and what it means to heal. The HMO raises questions about the nature of medical care and about justice which are anything but new.

When Jesus sent his disciples forth into the world, he "gave them authority to expel unclean spirits and to cure sickness and disease of every kind" (Mt 10:1). The question we must continually ask ourselves is by whose authority any of us proposes to heal today.

¹²⁹ Pellegrino and Thomasma, *For the Patient's Good* 185-87.

¹³⁰ George J. Agich and Charles E. Begley, "Some Problems with Pro-Competition Reforms," *Social Science and Medicine* 21, no. 6 (1985) 623-30.

¹³¹ Edmund D. Pellegrino, "Medical Morality and Medical Economics," *Hastings Center Report* 8, no. 4 (1978) 8-11.

¹³² John Paul II, n. 125 above.